~~S-E-C-R-E-T~~
(When Filled In)

COMPLETE IN DUPLICATE & RETURN BOTH COPIES TO THE INSURANCE BRANCH THRU APPROPRIATE ADMINISTRATIVE CHANNELS

HOSPITALIZATION APPLICATION
(CONTRACT PLAN)

*NAME OF EMPLOYEE _____
(First) (Middle) (Last)

DATE OF BIRTH _____

MONTHLY PREMIUM _____

MARRIED ☐ SINGLE ☐

SINGLE PLAN ☐ FAMILY PLAN ☐

FULL TIME EMPLOYEE ☐ YES ☐ NO

U.S. CITIZEN ☐ RESIDENT ALIEN ☐

COVERED BY PRESENT "10-UP" PLAN ☐ YES ☐ NO

*PLEASE NOTE: "Name of Employee" and "Employee's Signature" should agree with the one shown on contract with the Agency.

DO NOT WRITE IN THIS BLOCK.

POLICY NO. _____

EFFECTIVE DATE _____

CODE _____

(TO BE COMPLETED BY DIVISION)

_____
(PERSON TO CONTACT)

_____
(DIVISION) (EXT.)

_____
(ROOM NO.) (BLDG.)

DATE OF EMPLOYMENT AS CONTRACT EMPLOYEE _____

EMPLOYEE'S PAYROLL NO. _____

IS EMPLOYEE PAYROLLED
28 days ☐ Monthly ☐
Bi-weekly ☐

IF FAMILY PLAN, COMPLETE FOLLOWING:

NAME OF WIFE/HUSBAND _____
(First) (Middle Initial)

CHILDREN UNDER 19 (A protected person's children shall include unmarried children under age 19. Also, any step-children, legally adopted children, and foster children provided such children are dependent upon the protected person for support and maintenance.)

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH

I hereby authorize deductions from my salary for payment of premiums under this contract.

APPROVED:

_____
Administrative Officer of Division

*EMPLOYEE'S SIGNATURE _____
(See instructions above following*)

Date _____

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